PAXTON FAMILY DENTAL
www.paxtonfamilydental.com
DR. STEVEN DIETS & ASSOCIATES

# MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Chest Pains | ☐ Frequent Headaches | ☐ Hypoglycemia | ☐ Rheumatic Fever |
| ☐ Alzheimer's Disease | ☐ Cold Sores/Fever Blisters | ☐ Genital Herpes | ☐ Irregular Heartbeat | ☐ Rheumatism |
| ☐ Anaphylaxis | ☐ Congenital Heart Disorder | ☐ Glaucoma | ☐ Kidney Problems | ☐ Scarlet Fever |
| ☐ Anemia | ☐ Convulsions | ☐ Hay Fever | ☐ Leukemia | ☐ Shingles |
| ☐ Angina | ☐ Cortisone Medicine | ☐ Heart Attack/Failure | ☐ Liver Disease | ☐ Sickle Cell Disease |
| ☐ Arthritis/Gout | ☐ Diabetes | ☐ Heart Murmur | ☐ Low Blood Pressure | ☐ Sinus Trouble |
| ☐ Artificial Heart Valve | ☐ Drug Addiction | ☐ Heart Pacemaker | ☐ Lung Disease | ☐ Spina Bifida |
| ☐ Artificial Joint | ☐ Easily Winded | ☐ Heart Trouble/Disease | ☐ Mitral Valve Prolapse | ☐ Stomach/Intestinal Disease |
| ☐ Asthma | ☐ Emphysema | ☐ Hemophilia | ☐ Osteoporosis | ☐ Stroke |
| ☐ Blood Disease | ☐ Epilepsy or Seizures | ☐ Hepatitis A | ☐ Pain in Jaw Joints | ☐ Swelling of Limbs |
| ☐ Blood Transfusion | ☐ Excessive Bleeding | ☐ Hepatitis B or C | ☐ Parathyroid Disease | ☐ Thyroid Disease |
| ☐ Breathing Problem | ☐ Excessive Thirst | ☐ Herpes | ☐ Psychiatric Care | ☐ Tonsillitis |
| ☐ Bruise Easily | ☐ Fainting Spells/Dizziness | ☐ High Blood Pressure | ☐ Radiation Treatments | ☐ Tuberculosis |
| ☐ Cancer | ☐ Frequent Cough | ☐ High Cholesterol | ☐ Recent Weight Loss | ☐ Tumors or Growths |
| ☐ Chemotherapy | ☐ Frequent Diarrhea | ☐ Hives or Rash | ☐ Renal Dialysis | ☐ Ulcers |
| | | | | ☐ Venereal Disease |
| | | | | ☐ Yellow Jaundice |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____


# PATIENT REGISTRATION

**Patient Information**

First Name:_____ Last Name:_____ MI:____

Preferred Name:_____

Address:_____ Address 2:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

DOB:_____ SSN:_____ Drivers License:_____

Email:_____ O Opt-in to email appointment confirmations

Sex: M / F Marital Status: O Married O Single O Divorced O Separated O Widowed

Physician's Name:_____ Address:_____

Emergency Contact Name:_____

Emergency Contact Phone Number:_____

**Responsible Party (if someone other than patient)** Phone:_____

First Name:_____ Last Name:_____ MI:____

Address:_____ Address 2:_____

City:_____ State:_____ Zip:_____

**Primary Insurance Information:** Employer:_____

Policyholder Name:_____ Policyholder DOB:_____

Insurance Company Name:_____ Policy ID/SSN:_____

Group Number:_____ Patient relationship to Policyholder:_____

**Secondary Insurance Information:** Employer:_____

Policyholder Name:_____ Policyholder DOB:_____

Insurance Company Name:_____ Policy ID/SSN:_____

Group Number:_____ Patient relationship to Policyholder:_____


# HIPAA Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name: _____Date:_____

Signature: _____

Relationship to patient: _____
(if parent/guardian)

HIPAA OMNIBUS RULE

# PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

---

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message
□ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

---

**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) ___ _____

Signature of Privacy Officer

***HIPAA made EASY™***
©All Rights Reserved


# Missed Appointment Agreement

It is our philosophy to continue to put our patients first and to make your experience a positive one.

It is our **policy** for you to give us 48 hours' notice if you need to change an appointment.

We take our time to make courtesy calls to remind you of your appointment. **If you cancel or reschedule your appointment and fail to give us 48 hours' notice there will be a $50 charge**. If you miss the appointment a second time after rescheduling you must pay your coinsurance in full before we will schedule your treatment.

In regards to your dental treatment, we ask that you pay half of your cost share, including any deductibles, at time of scheduling whenever the total treatment exceeds $300 in total. This holds your appointment time and keeps you accountable to come to the appointment that we set aside for you.

Please understand that these policies were put into place because of an increase in no show appointments and last minute cancellations. We value your time but please value ours as well.

Thank you for allowing us to share our missed appointment policy with you and please let us know if you have any questions. We are committed to your oral health and keeping your scheduled appointment allows us to be partners in your dental care.

---

Patient Signature Date

---

Parents/Guardian Signature (if applicable) Date

PAXTON
FAMILY DENTAL
www.paxtonfamilydental.com
DR STEVEN DEETS & ASSOCIATES

**We are a Mercury-free office**!

The use of modern composite fillings (tooth colored fillings) and modern bonding techniques allows for less natural tooth structure to be removed. For this reason we advocate the use of composite fillings (tooth colored fillings) in conservatively treating or restoring decayed or damaged teeth.

"Mercury is highly toxic and harmful to health. Approximately 80% of inhaled mercury vapor is absorbed in the blood through the lungs, causing damages to lungs, kidneys and the nerves, digestive, respiratory and immune systems. Health effects from excessive mercury exposure include tremors, impaired vision and hearing, paralysis, insomnia, emotional instability, developmental deficits during fetal development, and attention deficit and developmental delays during childhood." The World Health Organization

We do not use amalgam (silver/mercury) fillings; patients are responsible for the cost difference between the amalgam (silver/mercury) compared to composite (tooth colored fillings).

I have read and understand the mercury-free standards of the Paxton Family Dental office. I agree to the cost differences if/when I would need fillings.

Patient's signature:_____ Date:_____

Parents/guardian signature:_____Date:_____

Print name:_____

PAXTON FAMILY DENTAL
DR STEVEN DEETS & ASSOCIATES
5690 Allentown Boulevard, Harrisburg PA 17112 (717) 526-2000 www.paxtonfamilydental.com

# ASSIGNMENT OF BENEFITS AGREEMENT
# FOR STEVEN DEETS, DMD

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.
- We require you to pay the **estimated** copayment, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an **estimate** of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

**I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.**

_____
Print Name of Patient or Responsible Party

_____ _____
Signature of Patient or Responsible Party Date

Paxton Family Dental
(717) 526-2000
(717) 526-6111
5690 Allentown Blvd.
Suite 100
Harrisburg, Pennsylvania
171128719
USA
records@paxtonfamilydental.com

# COVID Informed Consent

_____
Patient Name (Print)

## Supplemental Informed Consent - Dental Treatment in the Era of Covid-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus", at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dentist, dental staff, and sometimes other patients at all times.

## Although exposure is unlikely, do you accept the risk and consent to treatment?

- [ ] Yes
- [ ] No

## Screening Questions - Please Answer Honestly

- [ ] I have had a fever, or felt hot/feverish within the last 14-21 days.
- [ ] I am experience shortness of breath and/or have had other difficulties breathing.
- [ ] I am experiencing other flu-like symptoms (upset stomach, headache, fatigue).
- [ ] I have been in contact with a confirmed COVID-19 positive patient within the last 30 days (e.g. coworkers, family).
- [ ] I have traveled to a region heavily affected by COVID-19 within the last 14 days (e.g. New York, New Jersey, Philadelphia).

If any of the above apply, please explain.

-

- [ ] None of the above apply.

_____ _____
Patient Signature (Or responsible parent / guardian) Date